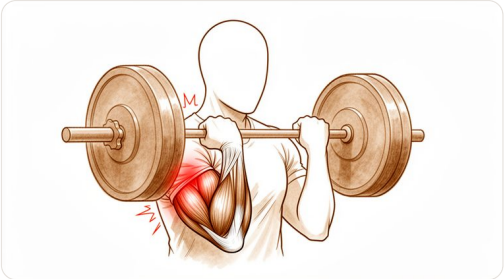
CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

Distal Biceps Repair



MRI of a torn distal biceps tendon: the tendon (arrow) has pulled away from the radial tuberosity. Repair re-anchors it back onto the bone.

Kieran Hirpara 4.0

At-a-glance recovery. Pooled from 45 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
2-6 weeks	**3-6 months**	**12 months**
Return to desk work and light activities typically occurs within 2 to 6 weeks, with workers' compensation patients taking longer.	Return to sport and manual work is typically achieved by 3 to 6 months, with high return-to-sport rates observed at 6 months.	Maximum recovery and plateau of functional outcomes typically occur at 1 year post-surgery.

Why this operation has been suggested

This operation repairs a torn tendon at the front of your elbow. Your surgeon likely suggested it because you have a complete tear that has not improved with non-surgical care. While some partial tears can be managed without surgery, surgery is the best option for complete tears to restore strength and function.

The main goal is to help you return to work and sport with high levels of satisfaction. Most patients recover well, though one in five will experience a minor complication and one in twenty will have a major complication. Despite these risks, the procedure offers excellent long-term results for restoring your arm's power and stability.

Before the operation

You will need to fast before your surgery and stop certain medications as your surgeon advises. Please arrange for someone to drive you home and bring a list of all your current medicines. You will wear comfortable clothing on the day. Your surgeon may order X-rays, an MRI, blood tests, or an anaesthetic review before the

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procedure. These checks help ensure you are safe for surgery and that your bone and tendon are ready for repair. Your operation will be done through a single cut on the front of your elbow.

On the day

You will arrive at the hospital and meet your anaesthetist to discuss your care. This operation is done under general anaesthetic. You will be fully asleep for the operation. Some patients may also have a regional nerve block for post-operative pain relief – the anaesthetist decides on the day based on your individual circumstances. Your surgeon will then take you to the operating theatre for the procedure through a single cut on the front of your elbow.

After the surgery, you will wake up in the recovery area. You will stay there until you are stable and comfortable. Most patients have minor complications like temporary nerve numbness that get better with time. Major complications are rare, affecting about 1 in 20 patients. You will be ready to go home once your team says it is safe.

What the operation involves

Your surgeon will make a single cut on the front of your elbow to reach the torn tendon. This open approach allows direct access to the injury site. The surgeon will carefully free the damaged tendon from surrounding tissue and clean it up.

Next, your surgeon will reattach the tendon to the bone at the front of your forearm. To hold it in place, small metal buttons or screws are used to secure the repair. This fixation method helps the tendon heal back to its natural position. The cut is then closed with stitches, and a dressing is applied to protect the area.

While other techniques exist, this single-incision method is chosen for its ability to provide good results with a low rate of complications. Your surgeon will work to restore the tendon's strength while protecting the nearby nerves during the procedure.

After the operation

You will wake up in the recovery ward where your pain will be managed. Your arm will be in a sling or brace with a dressing over the single incision. You can move your fingers and wrist gently right away. Most people go home the same day, but some stay overnight. You must have someone stay with you for the first 24 hours. Your surgeon may allow early motion to help you recover strength. You will feel some lengthening of the muscle at first, but this is normal.

Recovery

Your arm will feel stiff and sore for the first few days. You will likely wear a sling or brace to protect the repair while the swelling goes down. Most people find sleeping easier with pillows propped under their arm. Gentle movement is key, but you must follow your surgeon's rules on how much you can lift.

You will start simple exercises to keep your elbow moving without straining the new repair. Your physiotherapist will guide you through these steps as your strength returns. You can do light daily tasks like eating or brushing your teeth once the pain eases. However, you cannot drive or lift heavy objects until your surgeon clears you to do so.

As the weeks pass, the stiffness fades and your grip gets stronger. You will gradually return to work and sport as your arm heals. Everyone heals at their own pace, so your timeline may differ from others. Your surgeon and physio team will guide you through every step of this journey.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

You might notice a deep, throbbing pain that does not ease with simple painkillers. This could signal a major problem. You should call the clinic immediately if this happens.

Nerve injury is a known risk, especially for newly trained surgeons. You might feel numbness, tingling, or a loss of sensation in your forearm or hand. Most of these minor nerve issues resolve on their own with time, but you should mention any strange feelings at your next review.

Sometimes, extra bone can form in the soft tissue around the joint. This is called heterotopic ossification. You might feel a hard lump or notice that your arm feels stiff. Even if this occurs, your arm strength usually stays normal. Tell your surgeon if you feel a new hard spot or limited movement.

If you have a deep infection, you may see redness spreading from the wound or feel sudden swelling and warmth. This is serious. You must go to the emergency department or call your surgeon right away.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Call us if you have a fever, increasing redness, or discharge from your wound. Go to emergency if you feel sudden severe pain, swelling in your calf, or shortness of breath. Contact your surgeon immediately if you lose feeling in your hand or cannot move your arm. While minor nerve issues often resolve, any sudden change needs checking. Most patients recover well, but these signs require urgent care.

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COMPLICATIONS & CONSENT

Distal Biceps Repair

Complication rates from published literature

Pooled from 45 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Loss of motion or elbow stiffness	**5-10%**	Loss of terminal extension or forearm rotation; usually mild and improves with therapy.
Incomplete strength recovery	**5-15%**	Some patients do not regain full supination strength, particularly with delayed repair.
Lateral antebrachial cutaneous nerve injury	**4-10.8%**	Numbness or burning sensation along the outer border of the forearm is the most common complication; most cases (77.9%) are mild and do not cause functional limitations.
Heterotopic ossification	**2.1-13.5%**	Abnormal bone formation between the radius and ulna; double-incision has higher rate (7.2%) vs single-incision (1.2%); symptomatic cases cause reduced forearm rotation and may require surgical excision.
Retear or failure	**1.4-5.4%**	The tendon may re-tear or stretch out after repair.
Posterior interosseous nerve injury	**1.1-4.0%**	Injury to the nerve that extends the fingers and wrist is rare but serious, potentially causing weakness or paralysis of finger/wrist extension.
Reoperation	**0.6-5.4%**	Overall reoperation rates range from 0.6% to 5.4%, driven largely by rerupture and heterotopic ossification.
Infection	**0.2-2.4%**	Superficial infections respond to oral antibiotics; deep infections may require multiple washouts and prolonged IV antibiotics, and in severe cases the repair may fail.
Radioulnar synostosis	**0.1-2.8%**	The two forearm bones may join together with bone, severely limiting forearm rotation, requiring surgical excision of the bony bridge.
Brachial artery injury	**0.1%**	Vascular injury is extremely rare but serious, potentially requiring vascular repair.

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COMPLICATION	REPORTED RATE	NOTES
Radial fracture through drill hole	**Rare**	Fracture through the drill hole in the radial tuberosity; rare with modern cortical button techniques.
Median, radial, or ulnar nerve injury	**Rare**	Injury to median, radial, or ulnar nerves is rare; most are traction neurapraxias.

I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

PATIENT — PRINT NAME

SIGNATURE

DATE

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